Measurement and Transparency of Health Care Price, Cost and Quality

Key to Improvement

A Call to Action and Guide for Iowa Employers and Purchasers

IOWA EMPLOYER GROUP

2015

IOWA EMPLOYER GROUP

Message to Iowa Employers and Purchasers

This is a call to action to Iowa employers and other purchasers of health care in Iowa. It is time to step-up and realize the benefits of effective measurement and transparency for our organizations, our employees, and for Iowans.

This document provides a guide in order to achieve success. It is important that we work together and achieve critical mass.

Measurement and transparency has proven to be effective to stimulate quality improvement and help drive-out cost. It is also important to our employees and their families as they become more engaged as health care consumers.

We hope you will join us on this important project.

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Executive Summary

What will it take to improve health care patient safety and quality? Of the three major approaches – regulation/accreditation, financial incentives, and public reporting – the most promising is public reporting according to Lucian Leape, M.D., Harvard University. Likewise, price and cost transparency are necessary for market forces to be effective. Thus, measurement and transparency of cost and quality is the key to improvement in health care quality and to drive-out cost.

According to David P. Lind Benchmark, annual premiums in Iowa have more than doubled over the last 15 years from $2,268 to $5,975 for singles and from $5,928 to $14,981 for family coverage. To the surprise of many, health insurance premiums in Iowa are about the same as the national average when adjusted for cost of living. The quality of hospital care for Iowa privately insured is "Average" according to the Agency for Health Care Research and Quality. Additionally, there is wide variation in the cost and quality of health care in Iowa.

Iowa employers gave an overall statewide "D+" grade for cost transparency of Iowa hospitals, according to David P. Lind Benchmark. In addition, when comparing five regions in Iowa, Iowa hospitals received "D" and "F" grades on transparency in medical outcomes." The HealthCare Incentives Improvement Institute gave an "F" grade for transparency of physician quality of care in Iowa.

The Iowa Employer Group issued this report as a call to action by Iowa employers and purchasers of health care. It contains specific recommendations and serves as a guide to achieve effective measurement and transparency in Iowa. The report describes why this is essential to contain cost and improve quality. Valuable information is assembled on health care price, cost, patient safety and quality to increase knowledge and understanding.

Challenges and issues to achieve meaningful transparency in Iowa are identified. Also, leaders in measurement and transparency of health care price, cost and quality from across the U.S. are identified and a summary of their actions described. These leaders include Minnesota Health Information and MN Community Measurement; Washington Health Alliance, the Boeing Company and the Washington State Health Care Authority; the State of South Carolina; the State of North Carolina; the Pacific Business Group on Health and the California Healthcare Performance Information System; Massachusetts Price Tags on Health Care; Oklahoma City entrepreneurial doctors; the states of Massachusetts, Maine, Vermont, Virginia, Colorado and others who have established an All-payer claims databases (APCD) programs; and the Wisconsin Collaborative for Healthcare Quality.

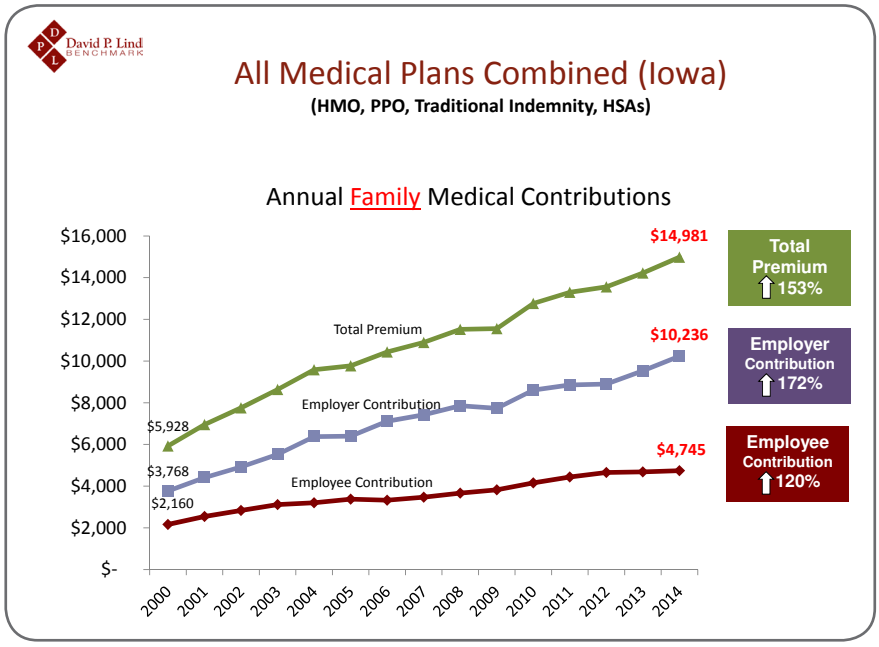
Finally, recommendations are included on pages 29 and 30. They include over-arching recommendations as well as specific action items.

Table of Contents

Introduction

While health care in Iowa has positive features, the cost of care continues to rise at a rapid rate and there are significant safety issues and wide variation in the quality and cost of health services. Employer-based health insurance premiums in Iowa are about the same as the national average. Likewise, the quality and safety of care remains at about the same as the national average. But the national average should not be our goal for either. Further, Iowa has low grades for transparency of health care quality and cost. We must do much better as health care is very important to people and is also a very significant business expense.

Iowa health insurance premiums have more than doubled over the last 15 years and employees and employer contributions are both rapidly increasing.



Source: David P. Lind Benchmark

A new group has been formed, the Iowa Employer Group. Its focus is to significantly increase performance measurement and transparency of health care quality outcomes and cost. The group points out that without information from measuring cost and outcomes of care, we cannot hope for improvement. With transparency comes clarity and accountability.

New developments in health care mean that consumers and patients need to take a more active, informed role. Demand for cost, patient safety and quality outcomes information is on the rise among consumers, patients and their families.

There is a lot of information and facts reported on health care. The intent of this report is to put together the whole picture and be a resource to stimulate a thoughtful and specific plan of action for improvement in Iowa. By illuminating the issues and taking action, health care providers, health plans, and others will hopefully pay more attention to the need for meaningful transparency and finding solutions.

Challenges

The Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote high-value care in the U.S. It has laid out the overall challenge.

With costs continuing to rise and consumers taking on an ever-growing share of these costs, the need for price and quality transparency is even more important. While there is some information available, more is needed along with tools and solutions useful to consumers and employers. The best tools and solutions will help consumers understand that more expensive care doesn't mean better care, and that more efficient care can be of great benefit to patients – it can indicate fewer unneeded tests and procedures and less time wasted in the doctor's office. The best tools and solutions will help consumers and employers truly understand the meaning of value, why they should care, and how they can identify high-value providers.

There is a need to understand the out-of-pocket costs, the full costs of care, and why both matter. From the perspective of employers and other purchasers, better tools will show the consumer this information - both the full price and their share of cost and explain why both are important in the long run. Similarly, the best tools and solutions should help steer consumers away from unneeded care and toward lower-cost alternatives.

In addition to the above, Iowa faces a second set of challenges. Generally speaking, health care providers and health plans here have not been forthcoming in support of cost and quality transparency meaningful to consumers and purchasers. Additionally, employers, purchasers, consumer groups and the State of Iowa have not been as proactive and effective as their counterparts in many other states. Thus, Iowa ranks low on various measurement and transparency ratings.

Issues to Achieve Meaningful Transparency in Iowa

Fifteen years after the Institute of Medicine (IOM) released *Crossing The Quality Chasm*, most experts agree there has been little overall improvement. There is little known, for the most part, on the quality of care delivered by the majority of clinicians and hospitals in the U.S. The same is true for the cost of care.
Ironically, the following quote by Goethe appears on the inside front cover of the IOM book: "Knowing is not enough; we must apply. Willing is not enough; we must do."

Iowa's current rankings:

- Health insurance premiums: Average
  (Source: Kaiser Family Foundation)
- Quality of hospital care for Iowa privately insured compared to the U.S.: Average
  (Source: AHRQ)
- Price transparency laws: "F"
  (Source: Catalyst for Payment Reform)
- Cost transparency of hospitals: "D+"
  (Source: David P. Lind Benchmark)
- Transparency of physician quality of care: "F"
  (Source: HealthCare Incentives Improvement Institute)
- Grading Iowa hospitals on "Transparency in Medical Outcomes": "D" and "F's"
  (Source: David P. Lind Benchmark)
- Ranking as a percent of hospitals reporting to Leapfrog Group: 3rd from last among the states (Source: Castlight Health)

Iowa can and must make significant improvements and become a leader. We must "apply" and "do".

Quality and Cost Measurement and Transparency

Section 1: Quality and Patient Safety Measurement and Transparency

Iowa employers gave Iowa hospitals "D" and "F's" on 'transparency in medical outcomes" according to the 2014 report by the Heartland Health Research Institute (David P. Lind Benchmark), *Voices For Value, Iowa Employer Perceptions of the Iowa Healthcare Provider Community*. Four regions "failed" while only the northwest region received a "high-D" grade.

In health care we know that recommended care is delivered about 55% of the time. (Note: "only 10 to 20% - sometimes up to one-half - of decisions are based upon the evidence or clinical guidelines." according to the Robert Wood Johnson Foundation from its Choosing Wisely Campaign, May 2, 2014).

55%

According to John T. James, in the *Journal of Patient Safety*, there are 440,000 deaths from preventable medical errors occur each year in U.S. hospitals. That makes it the third leading cause of death behind heart disease and cancer. In 2012, one out of every eight patients nationally suffered a potentially avoidable complication during a hospital stay, the government estimates. On any given day, at least one of every 25 patients in U.S. hospitals is dealing with an infection acquired during treatment. Preventable errors remain at this high level fifteen years after there was a national call to action. How can this be? Now there is a new call for performance accountability and transparency. There is a growing consensus that transparency of health care quality will help drive improvement in patient safety as well as in the overall quality of care.

"A preventable medical error becomes egregiously INTENTIONAL when nothing is done to prevent it from occurring again in the future." David P. Lind

In 1999, The Institute of Medicine published *To Err Is Human, Building A Safer Health System*. It was followed in 2001 by *Crossing The Quality Chasm*, A New Health System for the 21st Century. There has been other research reported on preventable errors and harm in health care.

These facts and events helped trigger some new measurement and public reporting on health care quality. This has been led by both the public and private sectors through such efforts as the CMS Health Care Compare, the Leapfrog Group, and The Dartmouth Atlas.

Even with these and other efforts there is wide variation in health care quality and much waste and harm. Helen Darling, CEO of the National Business Group on Health, recently stated that above all else waste and harm is the central issue in health care. The Institute of Medicine (IOM) estimates that 30% of the health care dollar is waste and inefficiency due to unnecessary services, inefficiently delivered services, missed prevention opportunities, excessive administrative cost and such.

Also, Lean Enterprise experts estimate that as much as 60% of the processes of providing health care are waste. Some health providers are beginning to apply Lean Enterprise to drive-out cost and improve quality as has been done in other sectors. However, to be effective this requires a fundamental change in culture of the organization. The focus is not on cost cutting, but rather on understanding what adds value to the end customer. The focus must be outward – on the customer and not inward – on what is good for the organization.

While efforts continue on research and measurement development, there is a growing recognition that it's time to use existing measures for transparency. Outcomes measures of quality and other measures of safety, effectiveness, timeliness and patient experience are especially important to consumers and purchasers. Also, most agree that a significant current shortfall and challenge is in communicating results to consumers and patients and effectively engaging them.

Section 2: Price Transparency – An Essential Building Block for a High-Value, Sustainable Health Care System

Iowa employers gave Iowa hospitals a "D+" on cost transparency and Iowa physicians a "C-" according to the 2014 report by the Heartland Health Research Institute.

Without price transparency it is difficult for anyone to understand the extent of price variation, its cause, or the ability of purchasers to address the problem. Also, some of the most promising payment reform approaches such as reference and value pricing cannot be implemented without price transparency.

There are three definitions or components of health care cost: 1) the health provider charged amount; 2) the negotiated amount by a third party (be it a health insurance company or Medicare or Medicaid); and 3) the amount for which the consumer or patient is responsible. The Catalyst for Payment Reform in its *Action Brief on Price Transparency* defined price transparency as "an estimate of the consumer's complete health care cost on a health care service or set of services that 1) reflects any negotiated discounts; 2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and 3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)".

"The only true measures of quality are the outcomes that matter to patients. And when those outcomes are collected and reported publicly, providers will face tremendous pressure –and strong incentives – to improve and to adopt best practices, with resulting improvements in outcomes."

Michael E. Porter and Thomas H. Lee, Harvard

Purchasers and consumers need transparency for three primary reasons: 1) to help purchasers contain health care costs; 2) to help consumers of health care make informed decisions as they assume greater financial responsibility; and 3) to reduce unknown and unwarranted variation in the system.

Consumers are taking on a greater share of their costs, including both health insurance premiums and out-of-pocket expenses. Also, enrollment in consumer-driven health plans (CDHP), such as health savings accounts is rising. According to a study commissioned by the American Association of Preferred Provider Organization, 61% of large employers and 48% of all employers expect to offer CDHP's five years from now. Consumers cannot be prudent health care shoppers without information on quality and price. Research shows that when they have access to well-designed reports on price and quality, 80% of consumers will select the highest-value health provider (Source: CPR Action Brief on Price Transparency).

Research also shows that significant price variation exists for hospital and physician services across markets and even within markets. Without price transparency, those who use and pay for care may be unaware of the range in potential costs and what little relationship it has to do with quality. Also, it is difficult to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

Hospitals in the greater Iowa market bill dramatically different for the same thing and are paid dramatically less than they bill Medicare. This all varies widely from hospital to hospital. See Table 1 below.

Table 1: How much hospitals charge for the same procedure (and what Medicare paid)

	Major Joint Replacement		Stent Insertion		Pulmonary Embolism	
Hospital name	Billed	Paid	Billed	Paid	Billed	Paid
Mayo Clinic – St. Mary's	$35,014 0.7x	$16,109 1.1x	$32,621 0.5x	$15,267 1.1x	$16,861 0.6x	$8,903 1.2x
University of Iowa, Iowa City	$48,762 1.0x	$19,804 1.4x	$55,276 0.9x	$19,286 1.3x	$19,869 0.7x	$9,651 1.3x
Mercy, Cedar Rapids	$35,990 0.7x	$10,878 0.8x	$61,056 1.0x	$11,375 0.8x	$17,101 0.6x	$5,420 0.7x
Iowa Methodist, Des Moines	$40,039 0.8x	$13,108 0.9x	$54,986 0.9x	$12,592 0.9x	$25,404 1.0x	$6,883 0.9x
Mercy, Des Moines	$33,023 0.7x	$13,348 0.9x	$46,047 0.7x	$12,625 0.9x	$17,996 0.7x	$6,962 0.9x
Mercy, Dubuque	$31,510 0.6x	$10,623 0.8x	$39,003 0.6x	$10,793 0.8x	$15,961 0.6x	$5,508 0.7x

Source: The New York Times, Business Day, May 2013. The "X" number represents the percentage to the national average.
(Note: The original source of this data was CMS which began the public release of hospital charge and paid date in 2013)

Another example of price variation is shown below. It shows more than a twofold difference in the total price for total knee replacement among greater Iowa hospitals. See Table 2 below.

Table 2: Total Knee Replacement (Surgery Code 8154)
Hospital Inpatient Pricing Data for Greater Iowa Hospitals

Name of Hospital	Average Charge Per Case
Lutheran Hospital, La Crosse, WI	$27,442
Allen Memorial Hospital, Waterloo, IA	$28,144
Rochester Methodist Hospital, Rochester, MN	$28,407
Grinnell Regional Medical Center, Grinnell, IA	$28,516
Franciscan Healthcare, La Crosse, WI	$32,520
Mercy Medical Center, Dubuque, IA	$32,546
St. Mary's Hospital, Madison, WI	$33,347
Finley Hospital, Dubuque, IA	$33,593
Great River Medical Center, West Burlington, IA	$35,092
Skiff Medical Center, Newton, IA	$35,481
Covenant Medical Center, Waterloo, IA	$35,552
Trinity Rock Island, Rock Island, IL	$35,582
University of Wisconsin Hospitals & Clinics, Madison, WI	$35,629
Mercy Medical Center – Westlakes, West Des Moines, IA	$35,948
Ottumwa Regional Health Care, Ottumwa, IA	$36,496
Pella Regional Medical Center, Pella, IA	$36,532
Genesis Medical Center, Davenport, IA	$37,493
Mercy Medical Center, Sioux City, IA	$37,905
Mercy Medical Center, Clinton, IA	$39,259
Olmsted Medical Center, Rochester, MN	$39,362
Spencer Hospital, Spencer, IA	$39,672
Midwest Surgical Hospital, Omaha, NE	$39,807
Mary Greeley Medical Center, Ames, IA	$40,291
The Nebraska Medical Center, Omaha, NE	$40,461
Mercy Medical Center, Cedar Rapids, IA	$40,515
Mercy Medical Center North Iowa, Mason City, IA	$40,714
Sioux Falls Surgical Center, Sioux Falls, SD	$40,842
St. Luke's Regional Medical Center, Sioux City, IA	$40,850
St. Mary's Hospital, Rochester, MN	$42,351
Jennie Edmundson Hospital, Council Bluffs, IA	$43,349
Trinity Regional Medical Center, Fort Dodge, IA	$43,555
Sartori Memorial Hospital, Cedar Falls, IA	$44,598
Avera McKennan Hospital, Sioux Falls, ND	$46,123
University of Iowa Hospitals and Clinics, Iowa City, IA	$46,657
Iowa Methodist Medical Center – Methodist West, Des Moines, IA	$46,878
Sanford USD Medical Center, Sioux Falls, SD	$46,920
St. Luke's Hospital, Cedar Rapids, IA	$47,144
Iowa Lutheran Hospital, Des Moines, IA	$48,287
Methodist Hospital, Omaha, NE	$48,722
Mercy Iowa City, Iowa City, IA	$53,153
Alegent Health Mercy Hospital, Council Bluffs, IA	$53,535
Alegent Health Immanuel Medical Center, Omaha, NE	$62,761
Alegent Health Lakeside Hospital, Omaha, NE	$64,361
Creighton University Medical Center, Omaha, NE	$73,894

Source: Hospital Pricing Specialists, 2013

The June 29, 2014 *USA Today* describes how "Utah Hospitals Try to Get Real" by a health system there tackling the nagging mystery of how much things cost. "To think that health care is this ginormous business that doesn't understand costs is mind-blowing," says Vivian Lee, Senior Vice President for Health Sciences at the University of Utah, an academic medical center with four hospitals and 1,330 physicians. "We don't know what it costs, so how can we manage it?"

Section 3: Price and Quality Transparency Efforts Underway by Health Plans, Vendors, States and Federal Government and Others

Health plans are beginning to share price and quality information with their members and developing tools to help them access and understand these data. The Catalyst for Payment Reform (CPR) reports that even with the most sophisticated tools, precise price transparency is still relatively rare. The Pacific Business Group on Health found wide variation in the functionality and cost comparison capabilities of health plans. In response, some purchasers are turning to third-party vendors to create tools for their consumers and employees. However, this requires health plans to release data to the third party vendor, which many health plans have not yet agreed to do.

Like health plan tools, other vendors' tools vary in function and scope of information they offer. Many focus on price or price estimates while others present quality and patient submitted reviews. Only a few provide comprehensive information on quality, price, patient experience, network providers and benefit design.

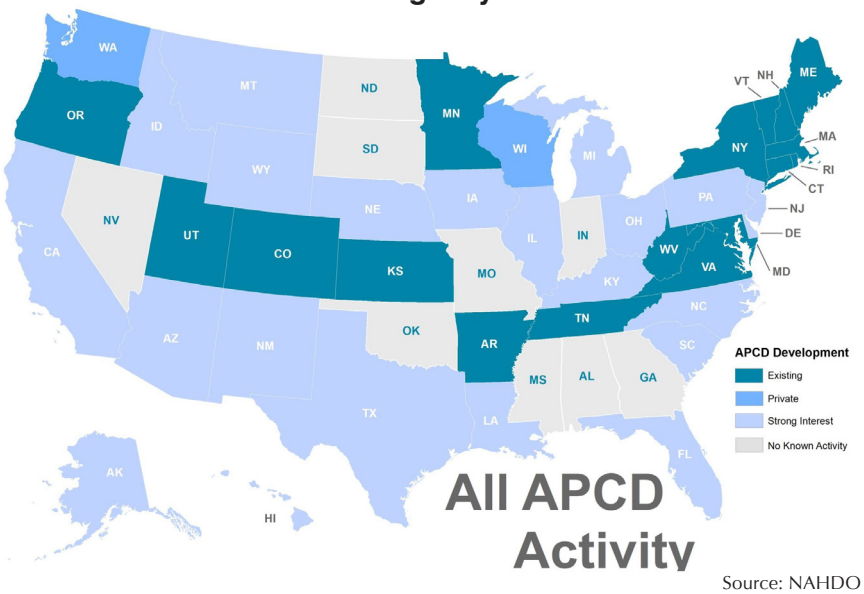
Three examples of vendors and tools:

Castlight Health, Inc. - Develops web applications that provides consumers with "clarity around their healthcare costs, usage, coverage, and choices". It enables employers and employees to make choices and lower costs. The firm's products are used in various companies in the United States. Castlight was founded in 2008 and is based in San Francisco. The Leapfrog Group has partnered with Castlight to analyze survey data.

Healthcare Bluebook – It is a "rational healthcare marketplace where informed consumers can save money by choosing to get their care from thousands of Fair Priced providers". It is a free resource.

Consumer Reports Shopping App - Hospital Advisory: Hip and Knee Replacement – The *Consumer Reports* is working on a tool to help consumers and patients find the right hospital and doctor. It compares prices and quality for hip and knee replacements. They are seeking study participants to help them better understand patient needs in order to incorporate them into the product.

State Data Agency Profiles



Source: NAHDO

More than 30 states require reporting of hospital charges or reimbursement rates and many states are pursing legislation to enhance price transparency in health care. According to the **National Association of Health Data Organizations (NAHDO)** there were 17 states operating all payer claims databases (APCD) as of December 2014 and many more interested. It reports that red and blue states have an equal strong interest and involvement. See map above.

NAHDO reports that this recent high interest in APCD was likely stimulated by the availability of federal grants through the Center for Consumer Information & Insurance Oversight. Cycle 1 grant funds are in the amount of $1 million. Cycle 2 and 3 awards are in the $4-7 million range. Many states are using the funds to increase transparency and to create an APCD system. Iowa is one of only a few states that have not sought funds from these grants

All Payer Claims Data Bases (APCD) are proving to be powerful tools for all stakeholders in states where they are used. They include data on diagnoses, procedures, care location, providers, and provider payments. According to Leavitt Partners, APCD bases can support market competition, monitor for market oligopolies, and show sources of high costs. "The emergence of such information would equip policy makers, researchers, and consumers with a deluge of useful information that could be leveraged in decreasing costs" Leavitt Partners stated in a February 2012 publication. Many health care providers also see the advantage of these data bases. Several provider leaders involved in the 2013 Iowa Metrics and Contracting Committee supported an Iowa APCD approach. Engaging and educating all major shareholders is important.

The federal government is also playing an important role in measurement, public reporting and performance transparency. This is underway in several programs as highlighted below.

The Center for Medicare and Medicaid Services (CMS), for the first time, is making publicly available provider utilization and payment data for procedures and services to Medicare fee-for services beneficiaries by specific inpatient and outpatient hospitals, physicians, and other suppliers. These data include information for the 100 most common inpatient services, 30 common outpatient services, and all physician and other supplier procedures and services performed on 11 or more Medicare beneficiaries.

In 2014 CMS released Medicare physician payment data. This is in follow-up to the hospital charge and paid data released for the first time in 2013 and referred to in Table 1. Periodic releases are planned for each of these and other suppliers as well.

Also, CMS makes available the **Health Care Compare** Website which has separate sites for hospital compare, physician compare, dialysis facilities compare, nursing home compare, and home health care compare. The Hospital Compare website includes information for timely and effective care, hospital mortality rates, complication rates, readmission rates, use of medical imaging, and results of survey of patients' experience (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS)). The Physician Compare website currently has only very basic information.

CMS is adding a **Five Star Ratings System** to the Health Care Compare website in 2014 and 2015. This will rate the quality of care of hospitals, physicians and other providers on a five star scale as follows:

- One star = Much below average
- Two stars = Below average
- Three stars = Average
- Four stars = Above average
- Five stars = Much above average

The **Agency for Healthcare Research and Quality (AHRQ)** produces and annually releases a Dashboard on Health Care Quality Compared to All States. Over 150 measures are in the National Healthcare Quality Report at the state level. State comparative measures are publically available by type of care, setting of care and care by clinical area in addition to overall performance.

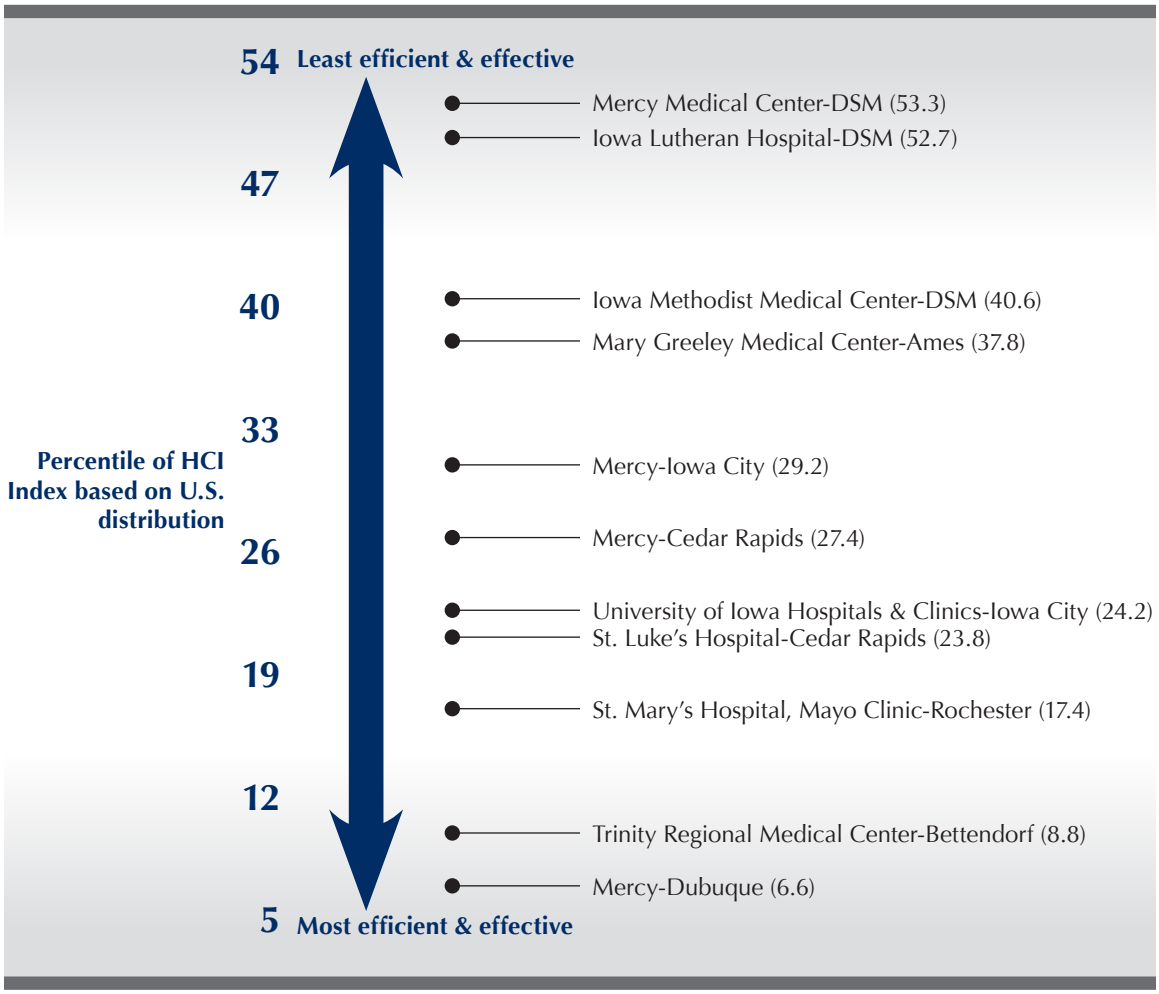
The **Leapfrog Group** is a national nonprofit organization using the collective leverage of purchasers of health care to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. It was founded in 2000 with support from the Business Roundtable and national funders and is now independently operated with support from its purchasers and other members. The flagship Leapfrog Hospital Survey allows purchasers to structure their contracts and purchasing to reward the highest performing hospitals. A blue ribbon panel of patient safety experts is guiding Leapfrog in a new initiative. It issues Hospital Safety Scores twice per year for more than 2,500 U.S. hospitals on how well they protect their patients from errors, accidents, and infections. This included 30 Iowa hospitals and numerous others in the greater Iowa market area. In the fall of 2014 Leapfrog announced a new consumer-friendly website. Consumers can quickly and easily get Hospital Safety Scores by individual market areas throughout the U.S. (www.hospitalsafetyscore.org.)

Twenty seven (27) states and the District of Columbia have implemented **Preventable Adverse Events (PAEs) reporting systems**. Iowa is not one of them. These reporting systems are intended to help address the critical issue of adverse medical events that cause patient death or serious harm in hospitals and other health care settings. Texas was the most recent state to join the ranks in January 2015. Most states prioritize communication of findings to providers and the public. Adverse event reporting often intersects with other patient safety efforts, making partnership across organizations an effective way to improve patient safety.

The Iowa Medicaid Program along with Wellmark Blue Cross and Blue Shield of Iowa has chosen **TREO Solutions** to help measure and report value with emerging Accountable Care Organizations in the Iowa market area. TREO Solutions is a healthcare data intelligence and analytic company. It prepares a value index score, the full score is based upon the following seven domains: 1) Member experience, 2) Primary and secondary prevention, 3) Tertiary prevention, 4) Population health status, 5) Continuity of care, 6) Chronic and follow-up care, and 7) Efficiency.

Researchers and vendors use this and other publically reported data in preparing performance scorecards and other reports. An example is the **Dartmouth Atlas of Health Care**. For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. One set of measurement is on the efficiency and effectiveness of health care systems. See the table below. Higher scores indicate higher intensity and thus less efficiency and effectiveness.

Efficiency and Effectiveness of Health Care Systems – Hospital Care Intensity



Source: The Dartmouth Atlas, 2014.

In 1999 the ABIM Foundation, a not-for-profit foundation established by the American Board of Internal Medicine, established the **Choosing Wisely** Campaign. It is a multi-year effort to help physicians be better stewards of infinite health care resources. The campaign addresses how patients and providers can and should discuss what medical tests and treatments are really needed. It has brought together more than 50 medical specialties to identify more than 250 tests and procedures that are commonly done, but may be unnecessary. It comes at a time when payment systems are beginning to change from those that are designed so that doctors get paid when they provide treatment and not paid when they do not recommend treatment.

The federal government is making large amounts of funds available to stimulate investment and use of health information technology to improve health care in Iowa and across the U.S. These funds involve financial incentives and eventually penalties to encourage the **"meaningful use" of electronic health records (EHR)** by health care providers. If done effectively, EHR can dramatically improve how care is delivered. It also has the potential to be a source of measurement and transparency. Also, in 2008 the Iowa General Assembly authorized the **Iowa Health Information Network (IHIN), which is Iowa's Health Information Exchange**. It will coordinate the interoperability of disparate electronic health records and allow for the robust exchange of electronic patient records. A patient portal is to be available, enabling patients to access their personal health information via the IHIN.

Section 4: The State of the Art of Price Transparency

Progress has been made in sharing information about the quality of care, with organizations like Bridges to Excellence and The Leapfrog Group leading the way and federal and state governments getting in on the act. But with recent studies showing that prices for an identical procedure within a market can vary seven-fold with no demonstrable difference in quality, price transparency is more important than ever.

While the private sector has made progress recently in making prices more available there are still large gaps. States can play an important role in ensuring that consumers have access to both quality and price information by setting policies and implementing laws that advance transparency. The most comprehensive, consumer-friendly laws ensure ready access to information and data about a broad range of providers and services.

The *Report Card on State Price Transparency Laws* was issued in March 2014 by the Health Care Incentives Improvement Institute as a joint effort with the Catalyst for Payment Reform (CPR). This year's report takes a deeper look at whether these laws were achieving the ultimate goal of ensuring consumers have access to meaningful information about the price of their health care. Thus, they expanded the scope of their inquiry to examine not only state laws on the books, but also states' price transparency regulations, price transparency websites, and all-payer claims databases (APCD), which CPR says is the ideal source of data for these websites.

The highest rated states are Massachusetts and Maine receiving "B" grades followed by Colorado, Virginia and Vermont all with "C'" grades. Iowa was among the states receiving an "F". Unlike other states, there are no efforts underway in Iowa to improve on this failing grade.

The only Iowa website shown in the report is a volunteer site operated by the Iowa Hospital Association, www.iowahospitalcharges.com. It was rated poor on utility, poor on ease of use and poor on scope. An arrangement between the Iowa Department of Public Health and the Iowa Hospital Association is the only item shown for Iowa under "State Laws on Health Care Price Transparency and Disclosure". Its scope of services is "inpatient, outpatient, and ambulatory information" and it states "department of public health shall (….) utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating".

Section 5: State Report Card on Transparency of Physician Quality Information

Research has shown that it is important that quality ratings of clinicians and hospitals be "consumable" to average patients. In its semi-annual publications on the Quality of Health Care in America, the Institute of Medicine called for the measurement and reporting of physician quality. That was in 1999 and 2000.

According to the HealthCare Incentives Improvement Institute many payers, including Medicare, require various forms of quality reporting, and use measures to "rate" physicians or trigger supplemental payment. And yet, finding information on the quality of physicians remains elusive for most consumers. While Medicare has a public web site that contains information on physicians, it is completely void of any data on the quality of care delivered. The CMS is planning to add a physician component to its Five Star Rating System on the Health Care Compare website in 2015.

The Institute reports that the **Aligning Forces For Quality (AF4Q)** effort has, to date, remained one of the few bright spots across the U.S. in providing transparent quality information to consumers. Similarly, with the support of large employers and some health plans, the **Bridges To Excellence (BTE)** was formed. It remains the country's largest and broadest effort to highlight and reward clinicians for quality care.

"Fifteen years after the Institute of Medicine's Crossing The Quality Chasm, we have no idea, for the most part, on the quality of care delivered by the majority of clinicians in the U.S. That's not just shameful, it puts patients at risk every day. We hope that by highlighting states that have made a conscious effort to provide these data to consumers will encourage others to embark on similar efforts."

HealthCare Incentives Improvement Institute

In December, 2013 the **HealthCare Incentives Improvement Institute** released its report *State Report Card on Transparency of Physician Quality Information*. It identified programs in 15 states with public reported quality information on physicians and reviewed each one. This information was used in preparing the report card along with the calculation of the percentage of total physicians in each state for whom quality information was publically available from community programs or from the Bridges To Excellence data base. The Institute gave a state by state report card with grades ranging from "A" to "F". Two states received an "A" – Minnesota and the state of Washington. California was next highest with a "C". Iowa was among the states graded as an "F".

Scoring and grading by state was based upon several factors. They included 1) the percentage of clinicians with transparent quality information, 2) the scope of measures reported, and 3) accessibility of information (Can consumers find it? Can they understand it? Is it useful?). The Healthcare Incentives Improvement Institute intends to update this state report card annually.

Two voluntary physician reporting or recognition programs should be noted. The National Committee for Quality Assurance (NCQA) operates a national Clinician Reorganization Program. Clinicians can voluntary participate and their level of recognition is publically reported for various patient practices such as medical home. Second, there is a growing number of clinical/physician registries which provide a source of doctor data. The Society of Thoracic Surgeons is one of the first to make some comparative data available for heart surgery outcomes. Surgery groups and hospitals are rated on a three star basis and the results made public on their website.

Section 6: Market Power in the Health Industry

Significant consolidation of health care providers, especially hospitals and physicians, continues in the greater Iowa market as well as around the nation. Representatives from the health industry point out the potential benefits of consolidation such as better coordination of services, more efficiency and such. However, they need to show results through meaningful transparency of their cost and quality. Are they really improving quality and driving out cost?

"Employer purchasers should expect decreased market competition absent any employer action"
Catalyst for Payment Reform

"The data collected and displayed by Aligning Forces For Quality and Bridges To Excellence remain the only widespread sources of publicly available information on the quality of clinicians."
HealthCare Incentives Improvement Institute

In its report the Catalyst for Payment Reform states that despite many efforts to "bend the trend", health care costs continue to rise at unsustainable rates, that price is a major driver of health care costs, and that behind the price increases is provider consolidation and market power.

"Health care economists broadly agree that provider consolidation is a major driver of price increases, and is also associated with significant payment variation across and within markets for both hospitals and physician services" the report says. Despite the potential benefits of consolidation, there is a fear – based upon well documented trends – that, unless it is managed carefully, massing provider power will lead to even higher prices and revenues. And, this excessive growth in health care expenditures is expanding toward unsustainable proportions without correlated improvement in quality."

Employers have a range of strategies that they can pursue in order to arrest further deterioration of market competitiveness or to improve competitiveness, some are market strategies and others are regulatory. The Catalyst for Payment Reform report describes potential ways to improve provider competition in health care costs and quality. These are described in three categories: 1) market-based approach, 2) coordinated public-private activities and 3) regulatory interventions.

Components of the market-based approach:

- Support price and quality transparency for consumers
- Support consumer engagement with benefit plan
- Support tiered, narrow and/or high performance networks
- Support centers of excellence and direct contracting
- Support managed care and managed competition (competitive health care financing and delivery system such as the Netherlands for example)
- Support oversight of Accountable Care Organizations (ACOs)

Components of the coordinated public-private activities approach:

- Align public-private payment and learn about new approaches such as episode-based and bundled payment, Accountable Care Organizations, global budgets or population-based payment methods
- Support All Payer Claims Data Base
- Support Pay For Performance (financial incentives that reward providers for meeting certain objectives such as CMS is doing)
- Increased emphasis on primary care
- Monitor antitrust activity, inappropriate use and health care fraud

Components of a regulatory intervention approach:
Health care purchasers can support a variety of regulatory efforts to combat the ill-effects of consolidation, including:

- Influence Federal Accountable Care Organization (ACOs) regulation efforts to help ensure ACOs foster enhanced affordability and quality and don't stifle competition;
- Support FTC efforts to monitor, and when appropriate, challenge consolidation;
- Influence the development of Federal regulations, such as improving the accuracy of the Medicare physician fee schedule and improving the Medicare inpatient and outpatient prospective payment systems, both help ensure appropriate volume and improve affordability;
- Support expanded department of insurance oversight and capability to intervene when providers exercise excess market power and engage in price fixing;
- Support active purchasing strategies for state exchanges to foster quality, affordability, and competition.

"There are several factors that have given rise to the lack of competition: 1) Hospital and physician consolidation; 2) Health benefit design that doesn't foster competition among providers; 3) Lack of information regarding provider performance."

Source: Catalyst for Payment Reform

More information on this topic and these approaches can be found in Appendix F – "Ensuring Competitive Markets for Health Care Services."

Section 7: The Role of Payment Reform

Medicare Payment Reform

Medicare and most other U.S. health plans have been volume-based purchasers with pay based upon the number of services provided regardless of the quality of care. Over the past decade, however, Medicare has been laying the groundwork to become a value-based purchaser of health services. One important step in this transition is accurately measuring value of care. In 2004, Medicare made data reporting mandatory and imposed financial penalties for failure to comply. Since 2005 quality data have been publically available on the Hospital Compare website. However, until 2012, hospitals actual performance on quality measures had no effect on the amount Medicare paid to providers for treating patients.

Medicare's Value-Based Purchasing Program - Hospital Value-Based Purchasing (VBP) is a part of the Centers for Medicare and Medicaid Services (CMS) long-standing effort to link Medicare's payment system to a value-based system to improve health care quality. HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payment to these models by the end of 2018. HHS has also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Initially, twenty-four (24) measures were being used to determine rewards and penalties by hospital. These 24 measures are grouped into three categories. The first 13 are measures of timely and effective care, also known as "process" measures. The second set of eight measures is culled from surveys of patients who had recently left the hospital. This is referred to as "patient experience" or "patient satisfaction" measures and are taken from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) survey. The third category of measures evaluated mortality rates for heart attack, heart failure or pneumonia. In 2014, the VBP program added its first measured medical outcome, a 30-day mortality measure for heart attack, heart failure, and pneumonia. Efficiency measures will be added in FY 2015.

Accountable Care Organizations (ACOs) Quality Performance Measures - The Shared Savings Program will award ACOs that lower their growth in costs for assigned Medicare beneficiaries while meeting performance standards on quality of care. CMS will measure quality of care using 33 nationally recognized measures in four domains:

- Patient/caregiver experience (seven Consumer Assessment of Healthcare Providers and Systems measures)
- Care coordination/patient safety (six measures such as readmissions and falls)
- Preventive health (eight measures: influenza immunization, pneumococcal vaccination, adult weight screening and follow-up, tobacco use assessment and cessation intervention, depression screening, colorectal cancer screening, and mammography screening)
- At-risk populations: Diabetes (6 measures), Hypertension (1 measure), Ischemic Vascular Disease (2 measures), Heart Failure (1 measure), and Coronary Artery Disease (2 measures)

In the future, Medicare plans to use pay-for-performance for physician compensation as well. Using quality metrics, a percentage of physician compensation can be tied to achieving specific clinical benchmarks in the care they provide.

Catalyst for Payment Reform Program – The Catalyst for Payment Reform (CPR) has set a target of 20% of payments being value-oriented by 2020. The results of the first National Scorecard on Payment Reform (2013) show that 11% of all commercial in-network payments were value-oriented either tied to performance or designed to cut waste. Within that 11%, most (57%) put providers at risk for their performance, though 43% offer a potential financial upside only. Progress toward value-oriented payment is evident but much more needs to be done.

The CPR has also issued an Action Brief on Improving Fee-For-Service Payment. The criteria used for selecting the short-term reforms include that it will lower cost, has positive impact on quality, and that the health plan can administer the reform. Most promising options identified are: 1) Reference and Value Pricing; 2) Maternity Care Payment Reform; 3) Reduction or Elimination of Payment for Undesired Events or Services; 4) Tiered Narrow Networks; 5) Pay for Web or other Asynchronous Doctor Services; 6) Patient-Centered Medical Home; and 7) Shared Savings. Numbers one and four above are consumer focused changes while the rest are provider focused changes.

Section 8: Challenges to Achieving Price Transparency

Three key challenges have been identified:
1) Lack of provider competition in the market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers. The CPR reports that a majority of national health plans have attempted to address this by removing so-called "gag clauses" from their contracts or working with providers outside of the normal contracting cycle to seek permission to share their price information in transparency tools.

2) Health plan restrictions on data – Due to restrictions from health plans, many self-funded purchasers face challenges with using their own claims data to build transparency tools for their consumers. According to the CPR, with third-party vendors increasing the options in the market, more purchasers are raising the issue of "who owns the data".

3) Unintended consequences of price transparency - For instance, price transparency without quality information could perpetuate consumers' misconception that price correlates with quality with some consumers thinking that higher priced care is better. Also, price transparency has the potential to generate higher prices and anti-competitive provider behavior.

"CPR purchasers expect providers to remove any restrictions on health plans from making price and quality information available for use in transparency tools – CPR purchasers expect health plans to allow self-funded customers full use of their own claims data including giving it to a third-party vendor to develop transparency tools."

Source: Catalyst for Payment Reform

Section 9: Key Elements of Comprehensive Transparency Tools for Consumers

Consumers must have access to meaningful, comprehensive information about the price and quality of services to make informed health care decisions. Such information should be readily available and accessible in a comprehensive format that is relevant and user-friendly, including:

- Integrated price, quality (especially outcomes data) and patient experience information for specific services that is customized to the consumer's benefit design (e.g., real-time deductible, coinsurance and co-pay information, etc.), by illustrating the total cost of care and the amount for which the consumer is responsible;
- Provider background, including education and medical training. Maintenance of Certification, services offered, access hours, location and online appointment scheduling; and
- An easy-to-use and convenient platform or portal including web and mobile applications, paired with support from physicians, nurses, coaches or other trained customer service representatives to help patients use the tools to maximize their health.

The CPR has developed a comprehensive set of specifications to help purchasers with health care transparency tools. The specifications fall into five categories:

1. Scope – the comprehensiveness of providers, including in-network and out-of-network providers, and service information, including price, quality and consumer ratings.
2. Utility – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality and care settings.
3. Accuracy – the extent to which consumers can rely on the provider, service and benefit information.
4. Consumer Experience – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
5. Data Exchange, Reporting and Evaluation – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool and the ability of users to rate the tool.

The above is from the Catalyst for Payment Reform. The CPR has developed 2014 Comprehensive Specifications for the Evaluation of Price Transparency Tools.

Section 10: Actions Purchasers Can Take To Drive Transparency (from CPR Action Brief)

Employers and other purchasers can and should play a central role in ensuring consumers and their families have access to comprehensive, easy-to-use tools that provide understandable information about health care quality and price. Actions purchasers can take:

1. Require their contracted health plan to:
    - Provide easy-to-understand price and quality comparison tools to consumers. (The CPR's Health Plan Request for Information, Model Health Plan Contract Language, and Specifications can support and guide this effort)
    - Help educate consumers about the benefits of using such tools and their functionality.
    - Allow purchasers to share their claims data with third-party vendors for building transparency tools for consumers or help with claims data analysis and interpretation.

2. Educate their consumers about how price and quality transparency tools can help them make important decisions about their health care and how to use them:
    - Use the Pacific Business Group on Health cost-calculator "Tip Sheet" to identify tactics to encourage consumers to register for and use their plan's cost calculator tools.
    - Encourage consumers to ask their physicians and other providers for an estimate of what they charge before receiving care.
    - Build on price and quality transparency tools with innovative benefit designs and payment programs, such as reference pricing and packaged-pricing for specific services like maternity care that will make the price information highly relevant.
3. Be vocal about the need for effective price and quality transparency:
    - Endorse CPR's "Statement on Transparency" and stand behind it in the sourcing, contracting and management of health plans and vendors.
    - Support health plans and other vendors who are developing these tools by sending the message to providers that transparency is important to you and your consumers – their patients.
    - Use CPR's Specifications for transparency tools in the development of a new tool or in the evaluation and comparison of existing tools.
4. Take part in statewide data collection efforts:
    - Statewide data collection efforts can improve access to credible quality and cost information. A fact sheet prepared by the All Payer Claims Database Council provides background information.
    - California Healthcare Performance Information System is a new voluntary multi-payer claims database in California.
    - If gag clauses or other contractual provisions between health plans and providers create barriers to the release of quality and price information, support efforts - voluntary or legislative - to make that information transparent.

Section 11: Remaining Challenges and Path Ahead

The market for price and quality transparency along with consumer-oriented tools and solutions continues to grow. Policymakers are becoming engaged in transparency as well at the national level and in many states. Also, many of the tools and solutions are much improved from the products just a few years ago. Most products have physician and hospital information in one place, have at least some information on both price and quality and offer the ability to compare providers by price and quality.

Additionally, the Catalyst for Payment Reform recently reported that gag clauses were becoming less of a concern for some health plans and price transparency vendors. And health providers themselves are becoming more supportive of the "very concept of transparency".

Many products need work before they meet the needs of consumers. Some fall short when it comes to how well they help consumers understand value: high-quality care at the lowest cost. For such products to help rein in health care spending, consumers need to understand their out-of-pocket costs, the full cost of their care, and why both are important. The best tools and solutions should help steer consumers away from unneeded care and toward lower-cost alternatives. With education campaigns like Choosing Wisely gaining strength, tools and solutions can build on this message to deliver timely prompts.

The CPR points out that unfortunately few patient members of health plans use the tools they offer such as cost calculator tools. Fortunately, several tools and solutions are developing engagement tactics based upon leading consumer behavior research.

While price information is more accessible and tools steadily becoming more robust, there is more work needed. Employers, purchasers, and consumers need to continue to push plans and providers so those hold-outs allow claims and other payment and price data to be shared unencumbered by gag clauses. State legislatures can do more to make quality and price information publically available. Organizations like the National Conference of State Legislatures (NCSL) and the National Academy of State Health Policy (NASHP) are recognized for helping policy makers as well as the Health Care Incentives Institute that has created and shared model legislation.

"Policymakers can and should use existing laws to monitor marketplace behavior, as they do in industries, to ensure that providers do not use price data in an anti-competitive manner." Source: Catalyst for Payment Reform

Examples of Leaders

- **Minnesota Health Information, A Guide to Health Care Quality and Cost in Minnesota and MN Community Measurement:** The Citizens Forum on Health Care Costs was formed by Governor Pawlenty and chaired by former Senator David Durenberger in 2003.The Forum found that health care consumers are too often left out in the dark about the quality and cost of health care.

  In response to the findings, a sub-group of the governors Health Cabinet created **Minnesotahealthinfo.org: A Guide to Health Care Quality and Cost in Minnesota**. The website is designed to provide Minnesotans with one place on the Internet where they can link to many resources of information on health care cost and quality. It is a "clearinghouse website" designed to offer a wide range of information about cost and quality of health care in Minnesota. The main categories of information on the site are: 1) comparing cost and quality, 2) assuring quality care, 3) buying health care, 4) managing your health condition and 5) staying healthy. The state plans to grow and improve the website over time.

  About the same time private sector leaders created the **MN Community Measurement**. It is a non-profit community organization. Its goal is to communicate fair, usable and reliable information about health care quality to providers, health care purchasers and consumers. Its mission is to accelerate the improvement of health by publically reporting health care information. The collaborative includes medical groups, clinics, physicians, hospitals, health plans, employers, consumer representatives and quality improvement organizations. These stakeholders support the idea that greater transparency (sharing of information) will lead to better health outcomes for people.

  MN HealthScores is one of their web based resources. It compares average prices and providers for over 100 common procedures such as blood tests, office visits and immunizations. Information and comparisons are available by clinics, hospitals and medical groups. This includes location, how often clinics provide care shown to get best results for a certain condition, how often hospitals provide recommended care and how many procedures they perform, what patients say about their care and use of electronic health records.

- **Washington Health Alliance, the Boeing Company and the Washington State Health Care Authority:** The Washington Health Alliance was formed in 2004 and was formerly known as the Puget Sound Health Alliance. Its membership has grown to include more than 175 state, county and private employers, union trusts, health plans, hospitals and physician groups, government agencies, community based organizations, educational institutions, pharmaceutical companies and individuals.

  The Alliance is a nonprofit, nonpartisan organization that shares the most reliable data to help providers, patients, and employers and union trusts make better decisions about health care quality and value. They set expectations for community performance on evidence-based practices that improve health while reducing waste and cost.

Its mission focuses on reducing overuse, underuse and misuse of health care services. Their vision is that by 2017, physicians, other providers and hospitals in the region will achieve the top 10 percent in performance nationally in the delivery of quality, evidence-based care and the reduction of unwarranted variation, resulting in a significant reduction in medical cost trends.

The **Community Checkup** is an annual report highlighting health care quality and value at medical groups and hospitals in Washington State. Comparative scores are available for medical groups, clinics, hospitals and counties. Hospital specific comparative scores are for patient experience (HCAPS), patient safety (using three Leapfrog measures), death (mortality) rates, meeting standards associated with better outcomes for high risk care, never events, readmission rates, surgical care – antibiotics, early elective delivery rates compared to goal rate and others. Medical group and clinic comparative scores include access to care (from state surveys), appropriate use of care (avoidance of antibiotics, X-rays, MRI and CT scans), generic prescriptions, health screening, patient experience and others.

The Alliance is working with several employers and exploring using claims data to measure the prevalence of certain tests and procedures included in the Choosing Wisely recommendations.

The Boeing Company is the Leapfrog Regional Rollout Leader in the Puget Sound and Wichita areas. Area hospitals have made great strides in Computer Physician Order Enrty (CPOE), electronic health records and intensives' coverage. Of the twenty six hospitals reporting to Leapfrog, ten fully meet the standard compared to three in 2001. It coordinates efforts with regional purchasers and labor organizations to support efforts to improve transparency within these markets and to promote informed health care decision making among its employees.

The Washington State Health Care Authority - "Coordinated health care, with quality results, at the lowest cost". The Authority oversees the state's two top health care purchasers — Medicaid and the Public Employees Benefits Board Programs. It is an active supporter and member of the Leapfrog Group.

- **State of South Carolina – align the public and private sectors to drive a market for improved care:** The focus is on reforming the delivery system by driving a market for best health care at the best price using transparency and payment. The hallmark is aligning the State with private sector players such as GE, Boeing, Wal-Mart, the Leapfrog Group and others. Thus the State and business community jointly exert a market demand for quality, transparency, and cost-effectiveness.

- **State of North Carolina**
  In 2013 North Carolina passed significant legislation mandating that hospitals share, on a new public website, price information based on paid amounts for common procedures. Thus, their first step is opening up the 'black box' of hospital billing that confuses consumers and blurs the basic concepts of a free market: paying appropriately for services of real value.

By improving transparency, North Carolinians can see for themselves the quality and cost of the services available to them and ultimately drive a market for the best care at the best price. The new law represents a huge step forward; last year the state only required charge data be shared in a report and by request.

- **<u>The Pacific Business Group on Health (PBGH) and the California Healthcare Performance Information System (CHPI):</u>** For 25 years the PBGH has helped purchasers nationwide improve the quality of health care and moderate the cost increases. Over the next five years (2015 – 2019), its priorities will continue to be improvement of health outcomes and the moderating of cost. The 1st strategic pillar is to accelerate transparency.

> Vision: A healthcare marketplace in which performance information is transparent, reliable and easily accessible by the public, rewards most effective providers, while also motivating purchasers and consumers to select high quality and cost-effective care.

Accelerate Transparency Projects: 1) The Health Plan Chooser; 2) The Patient Assessment Survey; 3) Supporting Consumers' Decisions in the Exchange; 4) Online Physician Rating; and 5) California Healthcare Performance Information System One resource is a website www.CalQualityCompare.org. It provides unbiased information about the quality of care for thousands of hospitals, medical groups, nursing homes and assisted living organizations.

The PBGH is one of the founding members of the Leapfrog Group and continues to serve as a Regional Roll-out Leader in California. Leapfrog reporting opened the door to a surge in statewide hospital level reporting efforts, which is now culminating in the CHART Initiative. CHART is designed to publically report the performance of California hospitals on a wide range of quality and safety measures.

The **California Healthcare Performance Information System (CHPI)** will be "producing the information Californians need to identify the best doctors". Its mission is to serve as a trusted source of healthcare information by accurately measuring the quality and cost of care, reporting performance ratings, educating the public about healthcare value, and helping drive improvements in healthcare in California.

CHPI is assembling a massive database and, once the rigorous statistical analyses and audits are complete, will release performance information to on-line publishers. The information will be used by health plans in developing high-performing networks and reported in member doctor directories. Furthermore, it will enable California consumers to make more informed care choices, fostering accountability among California doctors and incentivizing them to improve the quality of care.

CHPI is a public benefit corporation officially launched at the end of 2012 to serve as a voluntary multi-payer claims database. CHPI is designated as a CMS Qualified Entity. It has completed data intake of the CMS Fee-for-Service data and commercial claims (HMO, PPO, Medicare Advantage products) from the three largest plans in the state.

- **<u>Massachusetts, Maine, Vermont, Virginia and Colorado:</u>** These states are leaders among several states that have established databases that collect health insurance claims into statewide repositories. Known as "All Payer Claims Databases" (APCD) they are designed to inform policymakers and other stakeholders about various cost containment and quality improvement efforts. When well-designed databases collect the right information, they can transform data into valuable price and quality information.

According to the National Health Data Organization, seventeen states operate mandatory APCD's as of December 2014 and many more are being planned.

- **Massachusetts Price Tags on Health Care:** Massachusetts launched a new era of health care shopping in the fall of 2014. Anyone with private health insurance in the state can now go to his or her health insurer's website and find the price of everything from an office visit to a Cesarean section. For the first time, health care prices are public. They are the first state to require that insurers offer real-time prices by provider in consumer-friendly formats. There are some caveats since prices are not required to be standardized and may not include all charges. However, it is being called a "seismic event".

- **Texas requires reporting of Preventable Adverse Events (PAEs):** Texas is the most recent state to establish mandatory reporting of Preventable Adverse Events occurring in health care facilities, including hospitals and ambulatory surgery centers. It began January 1, 2015. The content from this reporting will be made public. PAEs that are required to be reported are: 1) health care-associated adverse conditions or events for which the Medicare program will not provide additional payment to the facility and 2) events included in the list of adverse events identified by the National Quality Forum.

- **The State of Maine and the Maine Health Management Coalition:** One-hundred percent (100%) of the hospitals in Maine report annually to the Leapfrog Group, motivated to do so by the State of Maine and a number of major employers. Maine also had the highest percentage of hospitals receiving an "A" grade in the latest Leapfrog Hospital Safety Scores at 80%.

There is a public/private partnership with the Maine Health Management Coalition. Its CEO Gerry Shea states: "The country cannot and will not see the sorely needed change in health care quality, safety and value without strong and assertive participation by consumers and purchasers."

- **Oklahoma City entrepreneurial doctors:** An Oklahoma City surgery center is offering a new kind of price transparency, posting guaranteed all-inclusive surgery prices online. The move is "revolutionizing medical billing" according to reports. (Note: Iowa does not have physician owned surgery centers or other such market alternatives due to state laws which limit entry into the market).

- **Wisconsin Collaborative for Healthcare Quality (WCHQ):** A study published in Health Affairs, conducted by the Wisconsin Collaborative for Healthcare Quality on the effect of public reporting found compelling evidence that public reporting led to improved performance in Wisconsin.

The WCHQ members are from health systems, medical groups, hospitals, and health plans. Its mission: publically reports and brings meaning to performance measurement information that improves the quality and affordability of healthcare in Wisconsin, in turn improving the health of individuals and communities.

Recommendations

Overall recommendations: Iowa employers and other purchasers must step-up and lead the way in order to attain needed measurement and transparency of health care performance on quality outcomes and cost/price. To be successful, a proactive and effective plan of action should be conducted in concert with each other and with other groups. The recommendations below are intended to be a starting point.

Iowa should continue to work on increasing quality outcomes transparency with a focus on applying available information while at the same time place new focus on obtaining and using price/cost information. In doing this, the experience of leaders in other states identified in this report should be considered. Advice and consultation should be sought from the Catalyst for Payment Reform.

Some specific recommendations:

1) **Identify 3 to 5 currently available measures for consumers -** Work should proceed as a priority to identify currently available standardized measures that consumers can understand and use: "What are the three to five things I should know about my provider?" Research and consult with others on what and how to make information available to consumers and patients so they will use it.

2) **Make results broadly available on Iowa websites -** Results from above should be made available and placed on Iowa employer and purchasers' websites. Also, this should be done by others including the State of Iowa (Iowa Department of Administrative Services, Iowa Medicaid, Iowa Insurance Division and Iowa Department of Public Health), labor organizations, and consumers groups.

3) **Take action to drive transparency -** The Iowa Employer Group and other employers and purchasers should consider taking action in accordance with Section 10 of this report entitled "Actions Purchasers Can Take To Drive Transparency".

4) **Encourage Iowa hospital participation in Leapfrog and use Hospital Safety Scores -** Specific action should be taken to encourage Iowa hospitals to participate in the annual Leapfrog Group Hospital Survey. Additionally, Leapfrog Hospital Safety Scores are currently available for some 30 Iowa hospitals (which account for most of Iowa hospital costs) and over 2,500 hospitals nationally. These scores should be made widely available to Iowa purchasers and consumers.

5) **Make available TREO measurement results -** The TREO measurement results used by the Iowa Medicaid and Iowa's Accountable Care Organizations should be made publically available on an ongoing basis.

6) **Elevate availability of price information as priority -** The State of Iowa should make the availability of meaningful health care price information a priority. In doing so, it should consider the North Carolina approach for making hospital price publically available. It requires that price information, based upon paid amounts for common procedures, be made publically available. Another option is the Massachusetts approach to "Price Tags on Health Care".

7) **Elevate physician cost/price and quality transparency as priority -** The measurement and transparency of price/cost and quality information for physicians and other clinicians should be elevated as a priority. Efforts by CMS, the Healthcare Incentives Institute and other states should be considered.

8) **Consider an Iowa All Payer Claims Database -** The State of Iowa should consider pursuing a grant from the Center for Consumer Information and Insurance Oversight to develop an All Payer Claims Database system (APCD). The National Association of Data Organizations reports there is an equal strong interest in APCD systems among red and blue states. Leavitt Partners point out that APCD systems can support market competition, monitors for market oligopolies, and show sources of high costs.

9) **Encourage Iowa survey to learn about patient safety experience -** Encourage a survey of Iowa adults (18+) to learn about their real-life experience with patient safety/medical error issues over the past five years. The results will serve as an essential baseline from which to assess any future progress on medical mistakes in Iowa. Also, by combining a large number of patient voices, this issue will be magnified to initiate support for increased health professional and statewide actions, either through care delivery improvement and/or public policy actions.

10) **Support health information technology and its Meaningful Use -** Support full development of the Iowa Health Information Network (Iowa's Exchange) and the Meaningful Use of health information technology. The Network has the potential to produce public reporting of health provider cost and quality performance information.

11) **Focus Lean transformation on the customer -** Lean transformation in health care should be encouraged. Experience shows that Lean will improve quality and drive out costs. *To make Lean successful and sustainable, the focus must NOT be on cost cutting, but rather on understanding what adds value to the end customer. The focus must be outward – on the consumer and NOT inward – on what is good for the organization.*

Appendix

Appendix A: Iowa Vision and Strategy Overview — Healthy and Productive Population

Quality Framework
Creating a Culture of Health

Quality of Life	Quality of Care
• Improve the health of population • Healthy lifestyles/behaviors • Health and wellness programs with biometric measures • Meaningful info for consumers	• Continuous improvement driven by metrics and Lean method • Meaningful information for consumers • Transparency of provider cost and quality outcomes performance • Payment reform (volume to value) • Consumer/patient engagement

Note.
Greater transparency of provider performance is (1) necessary to improve the quality, safety, and cost of health care and (2) give consumers much needed information to make decisions. In addition, reports on provider performance (3) give health plans and others information to guide contracting, tiering, benefit design, and pay-for-performance programs. Other industries provide comparative information on performance to enable consumer decision-making and stimulate market improvements. Health care should be no different. In fact, in health care, there is an even greater imperative to make useful information available because patients' lives and well-being are at stake."

What will it take to improve patient safety/quality? Of the three major approaches – regulation/accreditation, financial incentives, and public reporting – the most promising is public reporting and feedback to providers. Transparency is an idea whose time has come. Source: Lucian Leape, M.D., Harvard, 2010.
HPCI: 2014 – 2015

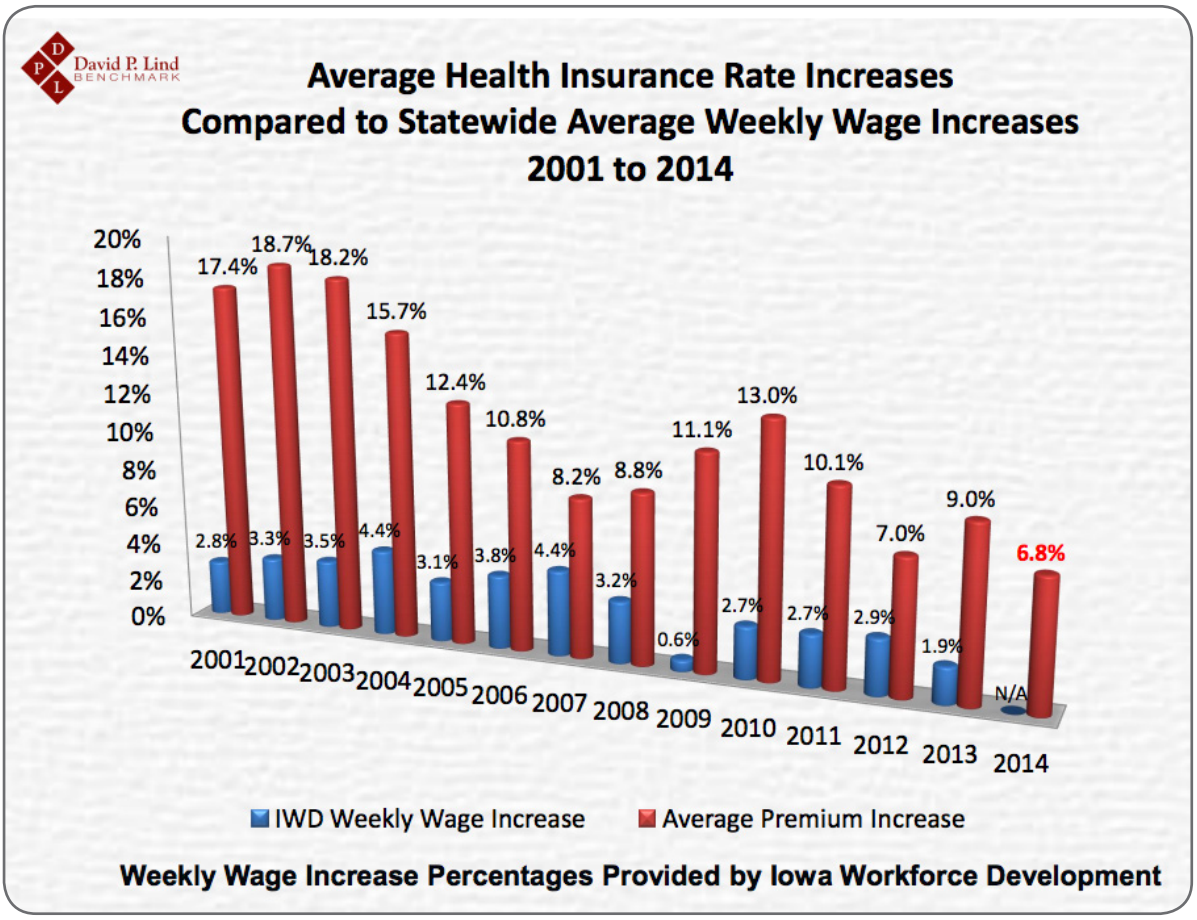
Appendix B: Health Insurance Premiums: Iowa Compared to U.S.

Type of Plan	Iowa	U.S.	Percent
Average Single per Enrolled Employee	$5,141	$5,384	0.95
Average Employee-Plus one per Enrolled Employee	$10,033	$10,621	0.94
Average Family per Enrolled Employee	$14,310	$15,473	0.92

Source: Kaiser Family, 2014 – based upon 2012 data for employer-based health insurance

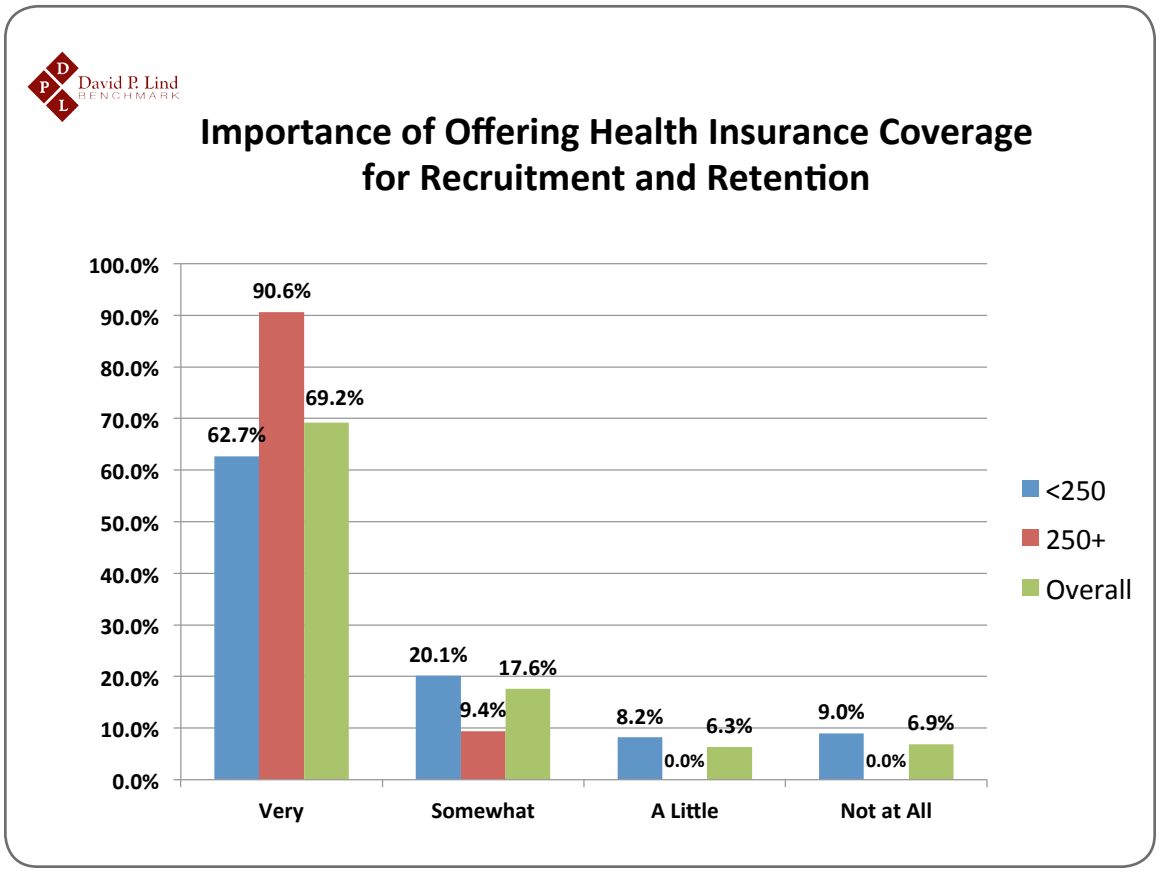
Cost of Living in Iowa was 10.6% below the national average making it the 6th lowest in the nation according to Wall Street Cheat Sheet, 2014. **Thus, Iowa employer based health insurance costs are about the same as the national average when adjusted for the cost of living.**

Appendix C: Average Health Insurance Rate Increases Compared to Average Weekly Wage Increases – 2001 to 2014



Source: David P. Lind Benchmark

Appendix D: Importance of Offering Health Insurance Coverage



Source: David P. Lind Benchmark

Appendix E: Importance of Healthcare Delivery Performance Indicators

HEARTLAND HEALTH RESEARCH INSTITUTE

Importance of Healthcare Delivery Performance Indicators

(Based on a 10-point scale, with 10 being "Most Important")

Performance Indicators	<250	250+	Overall
Keeping Costs Reasonable	**9.24**	9.06	**9.20**
Keeping Quality of Care Consistent	9.20	8.99	**9.15**
Safety of Care Delivered to Patients	9.13	**9.16**	**9.14**
Concern for Patient Satisfaction	8.83	8.76	**8.81**
Focus on Wellness and Health Promotion	8.52	8.49	**8.51**
Coordination of Care Between Providers	8.45	8.59	**8.48**
Access to Services	8.32	8.44	**8.35**
Ability to Engage Patients	8.35	8.34	**8.35**
Transparency of Medical Outcomes	8.09	8.47	**8.18**
Transparency of Costs	8.07	8.46	**8.16**
Health Providers Embracing Electronic Health Records	7.90	8.07	**7.94**
Efficiency in Care Delivered	7.90	7.93	**7.91**

2014-15 David P. Lind Benchmark

Appendix F: Ensuring Competitive Markets for Health Care Services

What steps can employers and other health care purchasers take to ensure care remains affordable in the face of growing consolidation?

Source: Catalyst for Payment Reform

Broadly speaking, purchasers can implement or support three different approaches: market-based, public-private, and regulatory.

Market-based Approaches

1. **Support price transparency for consumers**
   Allowing consumers, who are paying an increasing share of the costs of care, to select providers based on quality and price would motivate providers to compete in those domains, akin to how other non-health care markets function. With price variation as high as 700% for selected services in some markets and significant differences in quality, price information must be available to those who need to make decisions or who guide consumers in doing so (e.g., health coaches, nurses, and primary care physicians).[xxvii] Price transparency can also inform employers working to build long-term strategies to improve value. Some states collect and publish data on private sector prices and provide some limited information on provider quality and utilization patterns. A recent CPR Report Card on State Price Transparency Laws examined laws in all 50 states and concluded most were insufficient in ensuring that consumers had access to the information they need. Employers can help ensure any tools their health plans or third-party vendors provide meet consumers' needs by assessing them against CPR's Specifications for the Evaluation of Consumer Transparency Tools. Additional ideas are available in CPR's Action Brief on Price Transparency.

2. **Support consumer engagement with benefit design**
   Patients with comprehensive health insurance naturally tend to consume more services without much attention to value, which contributes to rising costs. Many benefit experts believe we could draw greater value from the health care system with plan designs that create the proper balance of incentives, information, and/or more restricted or higher-value provider networks. One of the primary consumer engagement strategies being used to support this goal is the Consumer-Directed Health Plan (CDHP), which typically pairs a health savings mechanism (e.g., HSA, HRA, etc.) with a high-deductible health plan.

   Value-Based Insurance Design (VBID) represents another attempt by employers and private insurers to engage consumers in making informed decisions about their care based on the identified cost, quality, and overall value of a specific drug or other medical therapy, service, or provider, while still retaining choice.

   Reference and value pricing live at the intersection of consumer engagement and provider contracting. Unlike VBID, reference pricing establishes a standard price for a drug, lab test, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. This creates the incentive for the plan member to use the preferred provider or the preferred class of services or therapies. Value pricing is

similar, but it also includes consideration of quality and/or other performance measurement in the equation determining the price point or preferred list of services or providers. Even though reference pricing has yet to yield sufficient volume to affect the overall pricing behavior of providers substantially, reference and value pricing have shown some promise when applied to high-cost and high-volume procedures such as joint replacements. See CPR's Action Brief From Reference Pricing to Value Pricing for more details.

3. Support tiered, narrow and/or high performance networks

Private payers somewhat successfully employed selective contracting—the use of limited networks of providers offering more favorable pricing—during the managed care domination of the 1980s and 1990s, and it is slowly gaining renewed attention. Despite having suffered from the backlash against managed care largely due to the lack of quality information in the development of managed care networks, renewed employer willingness and resolve to demand narrower networks could bolster health plans in their ability to negotiate with dominant and higher-cost providers in a particular area. A renewal of these strategies could foster competition among providers if coupled with appropriate quality and performance information, employee benefit designs, and decision-making support.

4. Support Centers of Excellence and direct contracting

Most major health insurers use Centers of Excellence (COEs) in a limited set of clinical areas (e.g., transplants, bariatric surgery, cardiac, orthopedics) to direct patients to facilities that have demonstrable strengths—better clinical outcomes, fewer complications and readmissions—for certain high-risk and/or high-cost procedures. More recently, several of the nation's large employers—most notably Wal-Mart Stores, Inc.—have begun to pursue direct contracting with COEs as a way to regain control over the costs of employee health care benefits.[xxviii] As a result, provider competition for direct contracting arrangements may well increase in the near term. And in some cases, direct contracting of this nature may be the beginning of efforts by some employers to circumvent private insurers. For the short term, COE contracting represents a way of injecting some competition into the market place while saving employers money and maintaining or potentially improving quality. Meanwhile some employers have begun direct contracting arrangements with provider systems. For example, technology giant Intel is pursuing a pilot program working directly with a provider system in New Mexico focused on creating medical homes for employees.[xxix]

5. Support managed care and managed competition

While deep suspicion about the concept among providers and consumers remains, if it had been handled differently, managed care might have evolved into a successful competitive health care financing and delivery system. According to health policy expert Alain Enthoven, to achieve its potential, certain market failures such as the absence and asymmetry of information must be addressed and benefit and enrollment practices must be structured to help create price-elastic demand. Many health policy researchers remain fans and there are examples, such as in the Netherlands, where this approach had some success in controlling costs while preserving a choice of providers. In an era of expanding health insurance exchanges, which have the potential to create more competitive models, both managed care and managed competition may once again be considered by purchasers as a means to improve competitiveness in health care.

6. Support oversight of ACOs

While many believe that consolidation or joint ventures are required to form an Accountable Care Organization (ACO), studies show that mergers may actually lead to substantial increases in prices with few or no measureable benefits.[xxx]

Instead, in providing oversight of ACOs, employers can communicate their expectations to their insurers/third-party administrators regarding how they will contract with and monitor the impact of ACOs.

For example, expectations could include: payment rates should reflect cost decreases; reaping savings should be contingent on improved quality; ACO providers will not engage in exclusive contracts; steerage can occur across and within ACOs; and enrollees should be given comparative information on provider performance, regardless of steerage.

Providers receive considerable antitrust exemptions under the provisions of the ACA and could use health reform as cover for additional consolidation and integration with the aim of increasing their market power. If they are not at the table, employers could be left with little leverage. View CPR's Toolkit on Accountable Care Organizations for more detailed information.

Public-Private Approaches

Employers and other purchasers of health care can also team up with public sector leaders to support a variety of strategies to combat the negative effects of increased provider consolidation and market power.

1. Align public-private payment and learn from the public sector about new payment approaches

Alignment of public and private payment strategies would have the benefit of providing more consistent incentives to hospitals and physicians and would likely reduce variation in prices and costs. Medicaid programs and private payers could consider aligning their payment methods with those of Medicare and assess where there is greater flexibility to consider those policies as a platform upon which to innovate further. There could be further alignment with, for example, episode based and bundled payments, shared savings, global budgets or population-based payment models, payments that emphasize the value of primary care, pay for performance initiatives, and the monitoring of inappropriate use of services and fraudulent practices.

The private sector can often learn from and emulate the public sector when it comes to success with these and other payment approaches. For example, recently, Medicare has experimented with payment systems that broaden the focus of physicians, hospitals, and other providers from delivering piecemeal, individual services to patients to providing the care a patient needs for an entire episode of illness or that an entire population needs over time. While bundled payments alone do not enhance competition among providers, they bring with them important incentives for providers to improve quality and contain costs.

Several private payers and the states of Maryland and Vermont are experimenting with the development of new versions of full- or partial-risk, population-based reimbursement arrangements for hospitals and their employed physicians. Like bundled payment, this payment method does not inherently enhance competition among providers. But these experiments hold promise for improving quality and containing costs as long as the state approaches can accommodate one of Medicare's existing payment methodologies or experimental alternative payment approaches (such as ACOs).

Private employers can also learn from Medicaid's payment reform efforts. For example, private employers and health plans have expressed interest in learning more about South Carolina's Birth Outcomes Initiative, a new payment reform program that combines patient and physician education with non-payment for unwarranted early elective deliveries. Organizations like CPR can help summarize the methods and outcomes of payment reform pilots in both sectors to facilitate cross-sector learning.

2. Support All Payer Claims Databases

Comprehensive and timely All Payer Claims Databases (APCDs) are necessary for the development of payment models using global budgets or shared-savings arrangements relating to a defined population. These data are necessary to perform a Medicare-like attribution of patients to multi-payer ACOs or Patient Centered Medical Home (PCMH) models. They also can be used to assess, make more transparent, and help integrate the highly disparate components of a state's health care financing and delivery system. APCDs can give employers and health plans better access to information about payment and quality variation, which can support value-based insurance design and a stronger negotiating position with providers.

3. Support Pay For Performance

The Agency for Healthcare Research and Quality defines pay for performance (P4P) as a strategy to improve health care delivery that, depending on the context, refers to financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payers, and improved quality and patient safety. Initial pilots by CMS and others have generated mixed results. Though limited to date by inadequate metrics and data, the continued development of useful and more meaningful metrics on care quality and patient experience of care, could help P4P initiatives have a large positive impact on both quality and cost. Consistency across P4P initiatives nationally, however, remains problematic and alignment of public and private strategies could help.

4. Increase the emphasis on primary care

Evidence suggests additional emphasis on primary care and substantial increases in reimbursement for primary care providers (PCPs) can help reduce costs and improve quality for patient populations,[xxxi] particularly for Medicare and chronically ill patients. More attention needs to be paid to giving PCPs the time and financial incentive to help engaged patients make the best referral decisions. Rebalancing payment between primary and specialty care can also put competitive pressure on specialists to demonstrate their value and to improve the appropriateness and quality of the care they deliver.

Regulatory Approaches

Regulatory approaches to provider market power can also be effective. However, state antitrust action is costly and involved and the likely success of each case is unpredictable. And while there are a wide range of strategies states can employ to promote competitive markets, there is an increasing trend toward regulatory and legislative provisions allowing providers to consolidate in the name of improving the coordination of patient care without being subject to antitrust regulations. Health care purchasers can support a variety of regulatory efforts to combat the ill-effects of consolidation, including:

- Influencing the development of federal ACO regulations to help ensure ACOs foster enhanced affordability and quality and don't stifle competition;
- Supporting FTC efforts to monitor, and when appropriate, challenge consolidation;
- Influencing the development of federal regulations, such as improving the accuracy of the Medicare physician fee schedule; and improving the Medicare Inpatient and Outpatient Prospective Payment Systems; both help ensure appropriate volume and improved affordability;
- Supporting expanded Department of Insurance oversight and capability to intervene when providers exercise excess market power and engage in price fixing, to help maintain competition and affordability at the state level and/or all-payer rate regulation as in Maryland; and,
- Supporting active purchasing strategies for state exchanges to foster quality, affordability, and competition.

WHAT DO WE EXPECT FOR THE FUTURE?

There is currently a great deal of market consolidation occurring. Frenzied efforts to form ACOs appear to be driving some of this change. Today, we have a limited line of sight into the true impact of provider consolidation and market power because of a lack of systematic and comprehensive monitoring. Given the growing awareness of the impact of increased provider negotiating leverage on rising health care expenditures, the appetite to develop a mechanism to monitor more broadly and rigorously the impact of provider consolidation on price may be at an all-time high. Representative health care claims data are also increasingly available, which could make such monitoring possible.

Efforts to improve price and quality transparency for consumers are proceeding at a slow pace and many purchasers have been hesitant to introduce radical changes in benefit design, especially when it comes to limiting networks. But given how greatly provider consolidation and market power are shaping the health care landscape, purchasers and others concerned about getting good value for their spending on health care will need to explore and implement strategies that create an environment conducive to improving the quality and affordability of care.

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Appendix G: The Iowa Employer Group's Vision on Cost and Quality

The first steps are measurement and reporting. Without information from measuring cost and outcomes of care, we cannot hope for improvement. With transparency comes clarity and accountability. The measurements need to be focused on quality and cost and must be presented in a way that payers (i.e. employers and Iowa Medicaid) and plan participants can understand and add value.

Cost
Cost = price per unit* x number of units *provider charges (claim), allowable amount, plan pay, patient pay

Quality
Quality of health provider focusing on outcomes -Overall -By specialty or procedure

More on Cost/Expense: The unit price can be "controlled", but the variability is the number of units that are ordered. Some of this variation is driven by an individual patient's needs, but just as importantly, the variation is driven by each individual practitioner's "way of doing things". The degree of practice pattern variation is dramatically different as evidenced by the Dartmouth Atlas.

In summary, putting unit pricing in the hands of the consumer is an important first step. However, that alone will not protect patients from practitioners who over prescribe meds, diagnostic studies and treatment modalities. There is an enormous opportunity for the system to ensure that accepted standardized treatment protocols are followed.

Example #1 - Diagnostic Imaging: *The allowed amount was $233 and # of units per patient ranged from one (1) to five (5). Almost 20% had more than one diagnostic image.*

Example #2 – Elective Surgery: *A woman from Sioux City is nearly six times more likely than a woman from Dubuque to have her breast removed to treat breast cancer. If you have heart disease and live in Davenport, you are more than three times more likely to undergo balloon angioplasty than if you live in Sioux City. Mason City residents are nearly twice as likely as Cedar Rapids residents to undergo back surgery. And men from Iowa City are three times as likely as men from Mason City to have a prostatectomy.*

More on quality outcomes and value: Quality outcomes include morbidity and mortality, patient safety, re-admission rates and patient experience among other key measurements. The goal is to achieve the highest quality outcomes at the lowest possible cost. This is maximum value. The approach is continuous quality improvement and driving out cost.

Appendix H: References and Sources of Additional Information

Catalyst for Payment Reform (CPR) – It is an independent, non-profit corporation working on behalf of large employers and health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S. The CPR is helping the largest health care purchasers understand how they can work together and with the public programs to get better value for our health care dollar – both on a national scale and in the individual markets. It has a national framework along with tools to catalyze change in the marketplace.

Their membership includes both private and public sector purchasers. These include large employers such as The Boeing Company, GE, 3M, The Dow Chemical Company, eBay, Safeway, Inc., Verizon Communications, Wal-Mart Stores, Inc. and Wells Fargo and Company. Public purchasers include the Medicaid programs in Arizona, Ohio, and South Carolina. The Tennessee and the Pennsylvania Employees Benefit Trust Fund and the Group Insurance Commission, Commonwealth of MA are also members. The CPR Website is www.catalyzepaymentreform.org.

Centers for Medicare and Medicaid (CMS) – It is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program and health insurance portability standards. It also has other responsibilities and has oversight of HealthCare.gov.

In Iowa, Medicare and the Iowa Medicaid program account for over one-half of all hospital inpatient charges (Medicare = 51% and Iowa Medicaid = 12%). They are also the major payer of outpatient services as well as other services such as nursing homes and home-health. The CMS website is www.cms.gov.

Castlight Health – A San Francisco based health care information company founded in 2008. It offers comparison tools showing price and quality metrics for tests and procedures offered by health care providers. Access to Castlight Health is through a business to business based subscription model. Only employees of companies which have purchased subscriptions are allowed access to Castlight Health's pool of pricing data. Customers include ConAgra, Cummins, CVS, Gordan Food Service (GFS), Liberty Mutual, The NCAA, State of Indiana, various universities and others. Their website is www.castlighthealth.com.

Choosing Wisely – It is a United States-based health educational campaign led by the ABIM Foundation. It seeks to improve doctor-patient relationships and promote patient-centered care by informing patients and physicians about overutilization of medical resources. The Foundation asked medical specialty professional organizations to make five recommendations for preventing overuse of a treatment in their field. Distributors then share this information with community groups nationwide and medical specialty sociality societies disseminate it to their members. The intent is that patients and doctors will discuss the recommendations in these lists, believing that if patients and doctors communicate with each other more effectively when making health decisions patients will have better outcomes and the medical system itself will benefit.

Consumer Reports is working with doctors to help patients avoid unnecessary and potentially harmful medical care. Its ComsumerReportHealth now has over 100 campaign partners including two in Iowa, the Iowa Healthcare Collaborative and HPCI.

CLEAR HEALTH COSTS – It is an organization of journalists committed to transparency. They are working to bring transparency to the health care marketplace by telling people prices for medical procedures and items. By revealing prices they seek to help consumers to make informed decisions about their medical care and coverage. Search engines and links are on their website www.clearhealthcosts.com.

Consumer-Purchaser Alliance – A national collaboration of leading consumer, employer and labor groups working together to promote the use of performance measurement in health care to inform consumer choice, value-based purchasing, and payment. Their mission is to strengthen the voice of consumers and purchasers in the quest for higher quality, more affordable health care. Their website is www.consumerpurchaser.org.

Consumer Reports – It is an American magazine published monthly by the Consumer Union since 1936. Health topics are appearing more often in the magazine and online. Additionally, a new health care project has begun along with a new magazine Consumer Reports Health. A Consumer Reports Shopping App is in the works "to help consumers find the right hospitals and doctors". They have partnered with ABIM Foundation and lead the consumer communication efforts of the Choosing Wisely campaign. Their website is www.consumerreports.org.

The Dartmouth Atlas of Health Care – For more than 20 years, the Dartmouth Atlas Project has documented glaring variation in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The research has helped policymakers, the news media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America. Its byline is "Understanding of the Efficiency and Effectiveness of the Health Care System". Their website is www.dartmouthatlas.org.

Healthcare Bluebook – It describes itself as a rational healthcare marketplace where informed consumers can save money by choosing to get their care from thousands of Fair Price providers. It is a free resource that shows a Fair Price for healthcare products and services to consumers. They advise that consumers should shop within their insurance network to find providers with Fair Prices. Health care providers can become a "Value Certified Provider". Those that do so and become Fair Price providers are said to be able to attract cost-conscious consumers. Their website is www.healthcarebluebook.com.

HealthCare Incentives Improvement Institute (HCI-3) – It aims to improve health care quality and value with evidence-based incentive programs and fair and powerful model payment reform. HCI-3 created programs to: 1) measure health outcomes; 2) reduce preventable care defects; 3) promote a team based approach to caring for patients; 4) realign provider payment incentives around quality and 5) reward excellence wherever it is found.

HCI-3 launched the Bridges To Excellence program in 2003. Its focus has been on clinicians, especially in the management of patients with chronic conditions. Much research has shown that clinicians that achieve a Bridges To Excellence Recognition deliver higher quality and lower costs of care than their non-recognized peers, especially for patients with chronic conditions. Since 2003 thousands of clinicians across the U.S. have become recognized for the quality of care they deliver. Their website is www.hci3.org.

Hospital Pricing Specialists LLC – They are a Silicon Valley based firm which provides "the very latest hospital pricing data" to consultants and health care executives. Articles on the firm and their findings have appeared in the WSJ, The New York Times, USA Today, Forbes and others. Some of their recent reports include: "The Odd Math of Medical Tests", "Hospital Prices – More Talk than Action", "Total Knee Replacement Pricing Report", "Echocardiogram Pricing Report", and "Colonoscopy Pricing Report". Their website is www.hospitalpricingspecialists.com.

Institute of Medicine (IOM) – It is an independent, non-profit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. Established in 1970, the IOM is in the health arm of the National Academy of Science, which was chartered under President Abraham Lincoln in 1863. The IOM asks and answers the nation's most pressing questions about health and health care.

In 1999, the IOM released To Err is Human: Building a Safer Health System. In 2001, IOM followed up with Crossing the Quality Chasm: A New Health System for the 21st Century. This landmark report outlined six "Aims for Improvement" which have been widely adopted by others. They are, health care 1) must be safe; 2) must be effective; 3) should be patient-centered; 4) should be timely; 5) should be efficient; and 6) should be equitable. The IOM website is www.iom.edu.

The Leapfrog Group – Its mission is to trigger leaps forward in the safety, quality and affordability of health care by: 1) supporting informed health care decisions by those who use and pay for health care and 2) promote high-value health care through incentives and rewards. Leapfrog works with employer members to encourage transparency and easy access to health care information.

The Leapfrog Hospital Survey is the gold standard for comparing hospitals' performance on national standards of safety, quality, and efficiency that are most relevant to consumers and purchasers of care. Leapfrog's Hospital Safety Score assigns A, B, C, D and F grades to more than 2,500 U.S. hospitals based on their ability to prevent errors, accidents, injuries and infections.

Funding was provided by the Business Roundtable (BRT) and The Leapfrog Group was officially launched in November 2000. It is now supported by its members and others. The website is www.leapfroggroup.org.

Leavitt Partners – It is a health care intelligence business founded and chaired by Michael Leavitt, former Secretary of the U.S. Department of Health and Human Services and three times elected Governor of Utah. Intelligence Centers include Medicaid, Accountable Care, Health Insurance Exchanges, Value Based Payment Systems and LP Speakers. The firm provides direct services to clients. Its website is www.leavittpartners.com.

National Association of Health Data Organizations (NAHDO) – It is a national non-profit membership and educational association dedicated to improving health care data collection and use. NAHDO's members include state and private health data organizations that maintain statewide health care databases and stakeholders of these databases. It is a cofounder and member of the All Payer Claims Database Council (APCDC), which provides leadership and technical assistance to states implementing APCDs. Its website is www.apcdcouncil.org. The NAHDO website is www.nahdo.org.

National Quality Forum (NQF) – It is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare. The NQF endorses consensus standards for performance measurement. Their website is: www.qualityforum.org.

Pacific Business Group on Health (PBGH) – Its mission is an influential change agent demanding increased value in the health care system. PBGH member organizations, private employers and public agencies, are "the most powerful voices for consumers and patients in the U.S. Ultimately, the profound concern of purchasers about high cost and poor quality of health care puts them on the same side as the American public when it comes to driving improvement throughout the health care system."

PBGH's approach is to use the clout and concentrated power of its member organizations to test innovative methods in specific markets, and then to take successful approaches to scale across the U.S. Its members include 60 public and private organizations across the U.S. that collectively spends $40 billion a year purchasing health care services for 10 million Americans. Their website is www.pbgh.org.


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